

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Dificid

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
☐ REQUEST FOR EXPEDITED REVIEW: By checking this box at the enrollee or the enrollee's ability to regain maximum function	nd signing below, I certify that the standard review timeframe may seriously jeopardize the life or health o on.
Drug Name:	
Strength:	
Directions / SIG:	
	y including labs and information for this member that may support approval. answer the following questions and sign.
	sis of C. difficile-associated diarrhea (CDAD) confirmed by a
☐ Yes	□ No
Q2. Does the patient require addition drug for therapy that was initiated in	nal medication to complete a 10-day course of the requested the hospital?
☐ Yes	□ No
Q3. Has the patient experienced an i to take to oral vancomycin?	nadequate treatment response, an intolerance, or is unable
☐ Yes	□ No
, , , , , , , , , , , , , , , , , , , ,	r a pediatric patient, have they experienced an inadequate or is unable to take oral metronidazole?
☐ Yes	□ No
Q5. Additional Information:	

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

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Patient Name:	Prescriber Name:	
Prescriber Signature	Date	
	2024 Prior Authorization Request	

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